		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046276

Facility Name: Metropolis Nursing & Rehab Ctr

Address: 2299 METROPOLIS STREET (Number) METROPOLIS (City) 62960-1393 (Zip Code)

County: MASSAC

Telephone Number: (618) 524-2634 **Fax #** (618) 524-2507

IDPA ID Number: 37-0859225002

Date of Initial License for Current Owners: 1/1/1965

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Karl Baker, BKD, LLP **Telephone Number:** 314-231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/3/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Clark Ribordy, THSCLLC, Mgt. Co.
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	17,108	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	94	TOTALS	94	17,108	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,954	2,296	1,160	9,410	8
9	SNF/PED	0	0	0		9
10	ICF	2,089	330	0	2,419	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	8,043	2,626	1,160	11,829	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.14%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/1965

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 1/0/1900 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 0 and days of care provided 1,160

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	60,175	6,239	3,418	69,832		69,832	(2,830)	67,002			1
2	Food Purchase		52,219		52,219		52,219	(165)	52,054			2
3	Housekeeping		4,472	39,596	44,068		44,068		44,068			3
4	Laundry		2,362	24,731	27,093		27,093		27,093			4
5	Heat and Other Utilities			51,534	51,534		51,534		51,534			5
6	Maintenance	19,235	4,892	30,729	54,856		54,856		54,856			6
7	Other (specify):*			2,355	2,355		2,355		2,355			7
8	**TOTAL General Services**	79,410	70,184	152,363	301,957		301,957	(2,995)	298,962			8
	B. Health Care and Programs											
9	Medical Director			2,580	2,580		2,580		2,580			9
10	Nursing and Medical Records	333,728	15,368	1,882	350,978		350,978		350,978			10
10a	Therapy		530	145,525	146,055		146,055		146,055			10a
11	Activities	14,698	368	6,369	21,435		21,435		21,435			11
12	Social Services	40,354	181	1,195	41,730		41,730		41,730			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	388,780	16,447	157,551	562,778		562,778		562,778			16
	C. General Administration											
17	Administrative	30,879	(2,098)		28,781		28,781	172	28,953			17
18	Directors Fees											18
19	Professional Services			106,091	106,091		106,091	(82,541)	23,550			19
20	Dues, Fees, Subscriptions & Promotions			9,266	9,266		9,266	(6,009)	3,257			20
21	Clerical & General Office Expenses	47,067	11,435	12,533	71,035		71,035	31,460	102,495			21
22	Employee Benefits & Payroll Taxes			45,177	45,177		45,177		45,177			22
23	Inservice Training & Education			284	284		284		284			23
24	Travel and Seminar			1,921	1,921		1,921		1,921			24
25	Other Admin. Staff Transportation			4,634	4,634		4,634		4,634			25
26	Insurance-Prop.Liab.Malpractice			31,124	31,124		31,124		31,124			26
27	Other (specify):*											27
28	**TOTAL General Administration**	77,946	9,337	211,030	298,313		298,313	(56,918)	241,395			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	546,136	95,968	520,944	1,163,048		1,163,048	(59,913)	1,103,135			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Metropolis Health Care Center #0011650 **Report Period Beginning:** 7/3/2003 **Ending:** 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			177	177		177	53,661	53,838			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			841	841		841	(1,842)	(1,001)			32
33	Real Estate Taxes			21,333	21,333		21,333	200	21,533			33
34	Rent-Facility & Grounds			100,179	100,179		100,179	(98,634)	1,545			34
35	Rent-Equipment & Vehicles			1,490	1,490		1,490		1,490			35
36	Other (specify):*											36
37	**TOTAL Ownership**			124,020	124,020		124,020	(46,615)	77,405			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		24,433	8,311	32,744		32,744		32,744			39
40	Barber and Beauty Shops			415	415		415		415			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,944	25,944		25,944		25,944			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		24,433	34,670	59,103		59,103		59,103			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	546,136	120,401	679,634	1,346,171		1,346,171	(106,528)	1,239,643			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,830)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(1,842)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(165)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,336)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,084)	21		24
25	Fund Raising, Advertising and Promotional	(6,009)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,255)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (22,521)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(84,007)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (84,007)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (106,528)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Metropolis Health Care Center

ID# 0011650

Report Period Beginning: 7/3/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (1,255)	21	1
2	Lobbying Portion of IHCA Dues	0	21	2
3				3
4	0	0	0	4
5	0	0	0	5
6	0	0	0	6
7	0	0	0	7
8	0	0	0	8
9	0	0	0	9
10	0	0	0	10
11	0	0	0	11
12	0	0	0	12
13	0	0	0	13
14	0	0	0	14
15	0	0	0	15
16	0	0	0	16
17	0	0	0	17
18	0	0	0	18
19	0	0	0	19
20	0	0	0	20
21	0	0	0	21
22	0	0	0	22
23	0	0	0	23
24	0	0	0	24
25	0	0	0	25
26	0	0	0	26
27	0	0	0	27
28	0	0		28
29	0	0		29
30	0	0	21	30
31	0	0		31
32	0	0		32
33	0	0	0	33
34	0	0	0	34
35	0	0	0	35
36	0	0	0	36
37	0	0	0	37
38	0	0	0	38
39	0	0		39
40	0	0		40
41	0			41
42	0			42
43	0			43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,255)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Metropolis Health Care Center **#** 0011650 **Report Period Beginning:** 7/3/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(2,830)	0	0	0	0	0	0	0	0	0	0	(2,830)	1
2	Food Purchase	(165)	0	0	0	0	0	0	0	0	0	0	(165)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,995)	0	0	0	0	0	0	0	0	0	0	(2,995)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	172	0	0	0	0	0	0	0	0	0	172	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(82,541)	0	0	0	0	0	0	0	0	0	(82,541)	19
20	Fees, Subscriptions & Promotions	(6,009)	0	0	0	0	0	0	0	0	0	0	(6,009)	20
21	Clerical & General Office Expenses	(11,675)	43,135	0	0	0	0	0	0	0	0	0	31,460	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(17,684)	(39,234)	0	0	0	0	0	0	0	0	0	(56,918)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,679)	(39,234)	0	0	0	0	0	0	0	0	0	(59,913)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Metropolis Health Care Center # 0011650 **Report Period Beginning:** 7/3/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation		53,661	0	0	0	0	0	0	0	0	0	53,661	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,842)	0	0	0	0	0	0	0	0	0	0	(1,842)	32
33	Real Estate Taxes	0	200	0	0	0	0	0	0	0	0	0	200	33
34	Rent-Facility & Grounds	0	(98,634)	0	0	0	0	0	0	0	0	0	(98,634)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,842)	(44,773)	0	0	0	0	0	0	0	0	0	(46,615)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(22,521)	(84,007)	0	0	0	0	0	0	0	0	0	(106,528)	45

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Tutera Health Care Svcs, LLC-Operating	100					
TI-Metropolis, LLC-Bldg Owner						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Building and Fixtures	$	Tutera Health Care Services, LLC		$ 1,545	$ 1,545	1
2	V	30	Movable Equipment		Tutera Health Care Services, LLC		440	440	2
3	V	21	Non Capital		Tutera Health Care Services, LLC		42,874	42,874	3
4	V	19	Professional Fees	84,743	Tutera Health Care Services, LLC			(84,743)	4
5	V	19	Legal Fees		TI-Metropolis, LLC		2,202	2,202	5
6	V	21	Data Processing		TI-Metropolis, LLC		261	261	6
7	V	33	Taxes		TI-Metropolis, LLC		200	200	7
8	V	17	Miscellaneous		TI-Metropolis, LLC		172	172	8
9	V	30	Depreciation		TI-Metropolis, LLC		53,221	53,221	9
10	V	34	Rent	100,179	TI-Metropolis, LLC			(100,179)	10
11	V	0	0						11
12	V	0	0						12
13	V	0	0						13
14	Total			$ 184,922			$ 100,915	$ * (84,007)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: TI-Metropolis, LLC
Street Address: 7611 State Line Road, Ste 300
City / State / Zip Code: Kansas City, MO 64114
Phone Number: (816-444-0900
Fax Number: (816-822-1723

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Legal Fees	Direct Cost	1		$ 2,202	$	1	$ 2,202	1
2	21	Data Processing	Direct Cost	1		261		1	261	2
3	33	Taxes	Direct Cost	1		200		1	200	3
4	17	Miscellaneous	Direct Cost	1		172		1	172	4
5	30	Depreciation	Direct Cost	1		53,221		1	53,221	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 56,056	$		$ 56,056	25

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Tutera Health Care Services, LLC
Street Address: 7611 State Line Road, Ste 300
City / State / Zip Code: Kansas City, MO 64114
Phone Number: (816-444-0900
Fax Number: (816-822-1723

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	34	Rent Expense	Direct Cost	163,989,581	15	$ 223,319	$	1,134,727	$ 1,545	1
2	30	Depreciation	Direct Cost	163,989,581	15	63,557		1,134,727	440	2
3	21	Clerical & General Exp	Direct Cost	163,989,581	15	6,196,056		1,134,727	42,874	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,482,932	$		$ 44,859	25

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Tutera Investments LLC		X	Working Capital			$	$		0.0625	$ 841	1
2			X		-							2
3												3
4												4
5												5
	Working Capital											
6	Interest Income		X								(1,842)	6
7	H/O Interest Income											7
8												8
9	TOTAL Facility Related						$	$			$ (1,001)	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ (1,001)	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 21,333	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 21,333	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	47	8
	1999	50	9
	2000		10
	2001		11
	2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Metropolis Health Care Center COUNTY MASSAC

FACILITY IDPH LICENSE NUMBER 0011650

CONTACT PERSON REGARDING THIS REPORT Junior Foster, THCSLLC, Mgmt. Co.

TELEPHONE (816) 444-0900 FAX #: (816) 822-1723

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,793 B. General Construction Type: Exterior BRICK Frame BRICK, BLOCK & ST Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization:
4. Dates Incurred: Various

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			2003	$ 290,485	1
2					2
3	TOTALS			$ 290,485	3

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	94		2003	1965	2,265,787	28,322	40	28,322	$	$ 28,322	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Automatic door closures (7)			2003	1,185	26	15	26		26	9
10	Chemical monitor for chiller			2003	1,684	-	5	-			10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37							$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	(DON'T ENTER BELOW THIS LINE)								63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,268,656	$ 28,348		$ 28,348	$	$ 28,348	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	355,932	25,050	25,050		10	25,050	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 355,932	$ 25,050	$ 25,050	$		$ 25,050	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,915,073	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 53,398	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 53,398	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 53,398	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. 0
This amount was calculated by dividing the total amount to be amortized 0
by the length of the lease 0 .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [0] NO

16. Rental Amount for movable equipment: $ 1490 Description: See attached detail for rental expense
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	949	$ 41,912	$ -	949	$ 41,912	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		95	7,767	-	95	7,767	2
3	Licensed Recreational Therapist		hrs		-	-	-			3
4	Licensed Physical Therapist	10a, 3	hrs		2,198	95,846	153	2,198	95,999	4
5	Physician Care		visits		-	-	-			5
6	Dental Care		visits		-	-	-			6
7	Work Related Program		hrs		-	-	-			7
8	Habilitation		hrs		-	-	-			8
9	Pharmacy		# of prescrpts		-	-	-			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs		-	-	-			10
11	Academic Education		hrs		-	-	-			11
12	Exceptional Care Program				-	-	-			12
13	Other (specify):				-	-	-			13
14	TOTAL			$	3,242	$ 145,525	$ 153	3,242	$ 145,678	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: 7/3/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 130,174	$	1
2	Cash-Patient Deposits	3,212		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	420,015		3
4	Supply Inventory (priced at)	7,072		4
5	Short-Term Investments			5
6	Prepaid Insurance	11,071		6
7	Other Prepaid Expenses	419		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	102,474		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 674,437	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,869		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	7,349		16
17	Accumulated Depreciation (book methods)	(177)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,856		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,897	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 686,334	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 617,177	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,212		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,909		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,593		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expenses	40,782		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 725,673	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 725,673	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (39,339)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 686,334	$	48

***(See instructions.)**

Facility Name & ID Number Metropolis Health Care Center # 0011650 Report Period Beginning: ###### Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3	**Restatements of Prior Year to allow rollforward**	(4)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(39,335)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (39,335)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (39,339)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,019,722	1
2	Discounts and Allowances for all Levels	(76,905)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 942,817	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	305,462	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 305,462	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,831	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	42,250	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,770	19
20	Radiology and X-Ray		20
21	Other Medical Services	7,608	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 55,459	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,842	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,842	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	1,255	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,255	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,306,835	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	301,957	31
32	Health Care	562,778	32
33	General Administration	298,312	33
	B. Capital Expense		
34	Ownership	124,020	34
	C. Ancillary Expense		
35	Special Cost Centers	33,159	35
36	Provider Participation Fee	25,944	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,346,170	40
41	**Income before Income Taxes (line 30 minus line 40)****	(39,335)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (39,335)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,310	2,353	$ 62,574	$ 26.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,516	1,548	30,572	19.75	3
4	Licensed Practical Nurses	4,681	4,745	77,820	16.40	4
5	Nurse Aides & Orderlies	17,639	17,925	146,622	8.18	5
6	Nurse Aide Trainees	1,592	1,611	11,301	7.01	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,257	1,302	14,698	11.29	10
11	Social Service Workers	2,063	2,103	40,354	19.19	11
12	Dietician	6,443	6,549	60,175	9.19	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,561	1,577	19,235	12.20	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	984	1,000	30,879	30.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,946	3,115	47,067	15.11	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	538	564	4,839	8.57	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	43,530	44,394	$ 546,136 *	$ 12.30	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	91	$ 3,308	1, 3	35
36	Medical Director				36
37	Medical Records Consultant	8	240	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	1,128	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	1,195	20	11, 3	44
45	Social Service Consultant	1,195	24	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,537	$ 4,720		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carol Johnson, Scott Stout	Admin.	0.00%	$ 30,879
			-
			-
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 30,879

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees		$
Purchased Service		7,315
Data Processing		12,053
Accounting		1,800
Professional Services		180
Management Fees		84,743
Trustee Expenses		
Home office allocation		(82,541)
		-
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 23,550

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,121
Unemployment Compensation Insurance	-
FICA Taxes	59,539
Employee Health Insurance	47,244
Employee Meals	-
Illinois Municipal Retirement Fund (IMRF)*	-
Other Benefits	722
Vacation benefits adjustment	(85,449)
	-
Home Office Allocation	
	-
	-
	-
TOTAL (agree to Schedule V, line 22, col.8)	$ 45,177

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A	-	$ -
	-	-
	-	-
	-	-
	-	-
	-	-
	-	-
	-	-
	-	-
	-	-
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,631
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Subscriptions	1,626
Advertising & Public Relations	6,009
	-
	-
Less: Public Relations Expense	(-)
Non-allowable advertising	(6,009)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,257

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,921
Seminar Expense	-
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,921

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **N** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **724** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **25,944**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **2,830**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **N**
Firm Name: **0** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N** If no, please explain. **0**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **NO**
Attach invoices and a summary of services for all architect and appraisal fees.